



EMSC/CHILD READY CONNECTION NEWSLETTER

JULY VOLUME 2, ISSUE 7

A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation*) is provided to children and adolescents, no matter where they live, attend school or travel.



Child Ready Montana- State Partnership of Regionalized Care (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME WITH THE RIGHT RESOURCES!

Exciting news and events are going on this month!

EMERGENCY PEDIATRIC CARE (EPC); FIREWORKS SAFETY; HYPERTHERMIA AND CARS; PEDIATRIC DISASTER TRIAGE; METH AND DRUG-ENDANGERED CHILDREN, AND SIGNS AND SYMPTOMS OF EXPOSURE! TRIVIA- ANSWER AND WIN PRIZES



EMS & Trauma Section
EMS for Children,
PO Box 202951,
1400 Broadway,
Room C314A,
Helena MT 59620

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NAEMT'S EMERGENCY PEDIATRIC CARE (EPC)



Emergency Pediatric Care (EPC) provides an advanced and in-depth scientific understanding of the pathophysiology of the most common pediatric emergency issues, and stresses critical thinking skills to help practitioners make the best decisions for their pediatric patients.

The course addresses a full spectrum of emergency illnesses, injuries and scenarios that an EMS practitioner might encounter and offers techniques that can help EMS practitioners rapidly and accurately assess life-threatening situations using the Pediatric Assessment Triangle (PAT), and incorporates family-centered care throughout all scenarios.

EPC is for all emergency medical technicians and paramedics committed to providing quality care for pediatric patients. Flexible course formats fit the continuing education needs of all EMS practitioners: traditional two-day face-to-face Provider Course, an accelerated two-day Provider-Instructor Course, and a Hybrid Course that combines eight hours of online training followed by one day of on-site interactive stations. This modular course format can fulfill the pediatric clinical and educational needs of an EMS agency while minimizing budgetary and logistical impacts.

Topics include: understanding kids; airway, breathing and oxygenation; cardiac emergencies; child abuse and neglect; common medical emergencies; the importance of family; hypo perfusion and shock; newborn resuscitation; pediatric trauma; and special health care needs.

COURSE CONTENT	EPC	PEPP
Hands-on Skills Station	*	*
Small Group Scenarios/ Critical Thinking	*	*
Pediatric Assessment Triangle	*	*
Topics:	*	*
• Understanding Kids	*	NO
• Child Development	*	*
• Respiratory Emergencies/ Airway	*	*
• Children with Special Healthcare Needs	*	*
• Trauma	*	*
• Medical Emergencies	*	*
• Child Maltreatment	*	*
• Cardiovascular Emergencies	*	*
• Congenital Heart Defects	Optional	NO
• Hypoperfusion and Shock	*	NO
• Neonatal Resuscitation	*	NO
• Family Centered Care	Optional	NO

The Montana EMS for Children's Program is seeking those interested in being an EPC Instructor. A commitment of at least 2 EPC classes per region per year is a requirement. Instructors must meet EPC requirements. A stipend will be paid as well as mileage reimbursements. If you are interested, please contact Robin at rsuzor@mt.gov.



CHILD READY MONTANA

Child Ready Montana is a State Partnership Regionalization of Care Grant (SPROC) funded by the Federal Health Resource and Services Administration (HRSA). Montana is one of 6 states to be awarded this grant with the Montana Emergency Medical Services for Children (EMSC) Program.

Child Ready Montana has completed the state wide site visit assessments. Assessments were conducted at critical access facilities, assessing pediatric emergent needs. Here are the **key findings**:

EASTERN:

Transport & Triage Protocols
Telehealth equipped and ready
Crisis debriefing

CENTRAL:

Transport & triage protocols
Certification class availability
Telehealth equipped and ready

***Cultural sensitivity training is needed across all regions**

Telehealth equipped/ready
Transfer protocols
Certification Class availability

Please stay tuned in the future for systematic phases of regionalization of pediatric emergent care in the state of Montana. If you have any questions please feel free to contact Kassie Runsabove at 406-238-6216.

Most Injured Body Parts



**JULY
FIREWORKS SAFETY
MONTH**

BE SAFE

<http://fireworkssafety.org>

HYPERTHERMIA: Every year, children die of heatstroke, also known as **HYPERTHERMIA**, while unattended in vehicles. The number of near - misses – children rescued before a fatality – is significantly higher. With concerted effort the Alliance, NHTSA and Safe Kids Worldwide offer preventable tips on need-less child heatstroke deaths in vehicles.

Heatstroke




NHTSA PROMOTES RESOURCES ON RISKS OF LEAVING KIDS ALONE IN HOT CARS

The National Highway Traffic Safety Administration (NHTSA) has [resources](#) available on the risks and consequences of leaving kids alone in hot cars. The resources also provide tips to avoid a tragic heatstroke and more information for safety advocates and professionals on how to get involved in this important issue.

SAFETY ADVOCATES AND PROFESSIONALS- Join NHTSA in tackling this important safety issue. Visit the Get Involved page for downloadable materials and assets for parents, caregivers, safety advocates and all those who want to help protect children from needlessly dying in hot cars.

http://www.safercar.gov/parents/heatstroke.htm?utm_source=EMSC+QuickNews%3A+May+22%2C+2014&utm_campaign=EMSC+QuickNews%3A+April+24%2C+2014&utm_medium=email



HEATSTROKE/HYPERTHERMIA

NEVER LEAVE A CHILD ALONE IN A VEHICLE

Safe Kids Worldwide Encourages Us to USE These Prevention Tips and ACT:

A

= AVOID

- Never leave your child alone in the car, even for a minute.
- Consistently lock unattended vehicle doors and trunks.

C

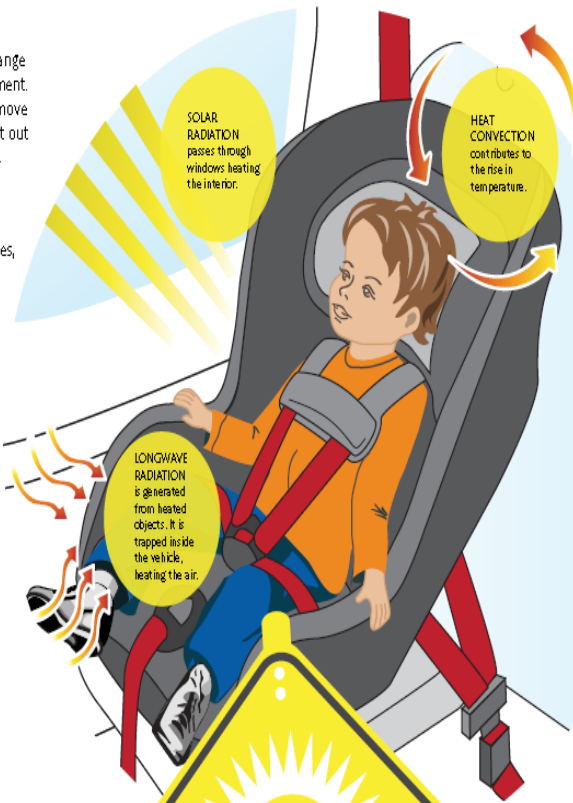
= CREATE REMINDERS

- Create reminders and habits that give you and your child's caregiver a safety net.
- Establish a peace-of-mind plan: call or text all other caregivers, so all of you know where your child is at all times.
- Put your cellphone, laptop or something else that you will need at your destination in the back seat to make sure that you have to look before leaving the vehicle.

T

= TAKE ACTION

- Dial 911 immediately and follow the instructions that emergency personnel provide – they are trained to determine if a child is in danger.



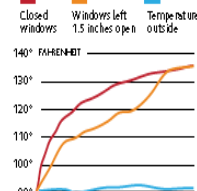
WHY CHILDREN ARE AT RISK

Their small bodies absorb heat more quickly. Perspiration doesn't cool infants and children as well as a adults. They can't change their environment. They can't remove clothing or get out of the vehicle.

WHAT DOESN'T WORK

PRIOR AIR-CONDITIONING
does little to prevent temperatures from rising. In five minutes, the car's interior temperature reaches that of outside air.

LEAVING WINDOWS OPEN
doesn't prevent the child from overheating.



HEALTH OUTCOME

THE LEVEL OF HEAT ILLNESS VARIES

- Length of time trapped in vehicle
- Time of day
- Child health status
- Car and child in direct sunlight

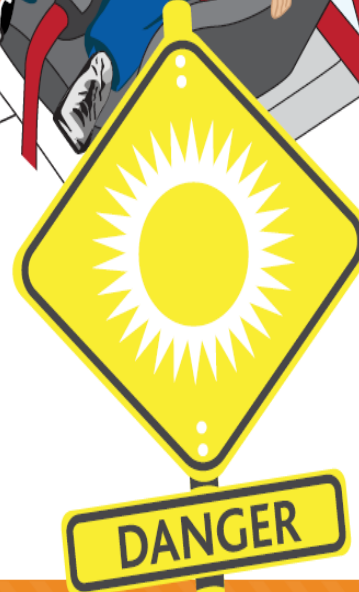
STAGES OF HEAT ILLNESS

Heat stress is a mild physical discomfort and physiologic strain.

Heat exhaustion is caused by dehydration when a child's temperature reaches 104 degrees. It leads to intense thirst, weakness, discomfort, anxiety, dizziness, fainting and headache.

Heatstroke or hyperthermia, is a life-threatening condition where the child's temperature rises more than 104 degrees, causing delirium, convulsions, coma and death.

SOURCES: Sun Sentinel. "Hyperthermia deaths of children in vehicles," Jan. 14, 2011, CDC, Department of Geoscience, San Francisco State University, [gweather.com/heat](#), "Quantifying the heat-related hazard for children in motor vehicles," Andrew Grundstein, John David, Vernon Meentemeyer, American Meteorological Society, "Heat Stress from enclosed vehicles: Moderate Ambient temperatures cause significant temperature rise in enclosed vehicles," Catherine McLaren, MD, Jan. 14, 2011, CDC and James Quinn, MD Pediatrics



EMSC and IHS Announce New Continuing Education Credits for Pediatric Disaster Triage Product (06/05/2014)

The Emergency Medical Services for Children (EMSC) Program, in collaboration with the Indian Health Service (IHS) Clinical Support Center, is pleased to announce that the 2010 Connecticut EMSC Targeted Issue Grantee Mark Cicero, MD product [Pediatric Disaster Triage: Doing the Most Good for the Most Patients in the Least Time](#) is now available with continuing education (CE) credits.

Targeting prehospital providers, this course contains five narrated modules addressing the following:

Recognizing a Disaster;

Disaster Triage Rationale;

Pediatric Triage Considerations;

Triage Methodologies (Jump START, SMART, SALT, and clinical decision making); and

Special Triage Decisions

http://www.emscnrc.org/EMSC_Resources/CME_Training/Disaster_Triage.aspx

NEW PEDIATRIC HEALTH CARE QUALITY MEASUREMENT AND IMPROVEMENT PORTAL



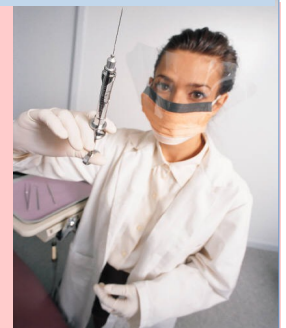
The Data Resource Center for Child and Adolescent Health (DRC), a project of CAHMI, has released a new Quality Portal. The portal is a comprehensive online resource regarding pediatric quality of care and improvement.

For more information: <http://childhealthdata.org/browse/qualityportal>

HEALTHCARE WORKERS: PROTECT YOURSELVES!

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases.

If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines.



The term "healthcare workers" includes physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff.

The CDC has updated its website on the topic and recommends the following vaccines for HCWs: Hepatitis B, Influenza, Measles Mumps and Rubella (MMR), Varicella, Tetanus, Diphtheria, and Pertussis, and Meningococcal (if routinely exposed to N. meningitides.)

For more information <http://www.cdc.gov/Features/healthcareworkervaccines/index.html>

METH

A synthetic stimulant that affects the central nervous system

Full name: Methamphetamine

Nicknames: Ice, speed, chalk, crystal, glass, crank, yaba, fire, tina, tweak, poor man's cocaine, uppers, trash, yellow bam, methlies quick, stove top, go-fast

Composition: Pseudoephedrine, a decongestant, and a number of toxic ingredients like lye and drain cleaner

Form: White or yellowish crystalline powder, crystals, or a pill

Use: Snorted, smoked, injected, or swallowed

Addiction Factor: Extreme—one of the most addictive substances



<http://www.methproject.org/answers/what-is-meth.html#The-Drug-Defined>

WEBINAR - DRUG-ENDANGERED CHILDREN

This presentation discusses the direct and indirect effects that the common drugs of abuse—meth or methamphetamine, cocaine, marijuana, prescription opiates and PCP can have on children. An overview of pre-natal drug exposure as well as drug exposure in the home will be given along with information about the difference in screening vs. confirmatory drug testing. Unique features of methamphetamine production in the home will also be discussed.

Dr. Farst is a pediatrician with the University of Arkansas for Medical Sciences (UAMS), Department of Pediatrics, and Center for Children at Risk. She completed undergraduate and medical school at Texas Tech University and then completed residency in Internal Medicine and Pediatrics at UAMS from 1995 to 1999. After several years of private practice in Rogers, AR and work with the Benton County Children's Advocacy Center, Dr. Farst completed a fellowship in child abuse medicine at Cincinnati Children's Hospital Medical Center and returned to UAMS in 2004. She is board certified as both as a general pediatrician for her work in the Emergency Department and child abuse pediatrician with the Team for Children at Risk at Arkansas Children's Hospital

Please note: A one-time registration to create a user ID and password is required to access free NCAC online training. [Access Recorded Presentation](#) (Course ID: NCAC-W-007); For more information, contact Ann Leith at aleith@nationalcac.org.

You need JavaScript enabled to view webinar. The webinar is available on-line on demand.

EFFECTS ON CHILDREN

Threats faced by children exposed to meth labs include the following. Chemical contamination.

A recent study of meth labs found that “chemicals spread throughout the house. The methamphetamine is deposited everywhere, from walls and carpets to microwaves, tabletops and clothing. Children living in those labs might as well be taking the drug directly.” Indeed, approximately 35% of children found in meth labs test positive for toxic levels of chemicals in their bodies, including meth.

Children in meth labs most commonly come into contact with chemicals through inhalation and absorption through the skin. Long-term exposure to meth lab toxins can damage the nerves, lungs, kidneys, liver, eyes, and skin. It is not uncommon for children removed from meth labs to have chemically-induced asthma or pneumonia that clears up after the children are out of the lab.

Experts report that approximately one in every six meth labs seized by authorities is discovered because of a fire or an explosion caused by careless handling and overheating of volatile, hazardous chemicals and waste and unsafe manufacturing methods.

WHAT SIGNS AND SYMPTOMS WOULD A CHILD LIKELY DISPLAY AFTER BEING EXPOSED TO THE ENVIRONMENT IN A CLANDESTINE LABORATORY?

There is no single, well-defined expected presentation for a child with a history of potential chemical exposure in a methamphetamine laboratory. Recent exposure to methamphetamine itself will likely cause a picture of sympathetic excess (tachycardia, hypertension, hyperthermia, etc.)

A child with a more distant serious exposure to methamphetamine may present with CNS depression, neurological deficit or coma due to catecholamine depletion. It is important, however, not to focus only on the toxicity of the finished drug product. In point of fact, there are an untold number of potentially harmful chemicals with which a child could come in contact in a clandestine laboratory.

The two most common complaints in adults following exposure to a clandestine laboratory are irritant (eye, skin or mucus membrane) and respiratory difficulties. Evidence of irritation such as caustic burns, redness, swelling, etc. may or may not be apparent. Respiratory compromise, ranging from wheezing due to irritation to pneumonitis from aspiration of hydrocarbon solvents to respiratory arrest from inhalation of gases such as phosphine or cyanide, is possible in a clandestine laboratory.

Finally, the child should be evaluated for signs or symptoms of abuse, neglect and nutritional deficit and, if present, further evaluation as deemed necessary should be completed.

<http://www.swaincountydss.org/methinfo.html>

Though methamphetamine affects urban communities as well, it has a proportionally greater influence in rural areas. In a survey conducted between 2002 and 2005, the Department of Health and Human Services found that:

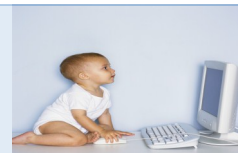
MONTANA WAS TIED (WITH WYOMING) FOR THE SECOND-HIGHEST RATE OF METHAMPHETAMINE CONSUMPTION AMONG PERSONS AGED 12 AND OLDER, trailing only Nevada.

Rounding out the top five states were Idaho and Nebraska. Suppliers usually set up “mom and pop” labs in homes or cars, and the relative isolation of rural areas makes it easier for these labs—and the toxic waste they produce—to escape detection. http://www.philanthropyroundtable.org/topic/excellence_in_philanthropy/lassoing_montana_meth

Rescue. Defend. Shelter. Support.



EXAMINE YOUR OWN CULTURAL COMPETENCE-TAKE A QUALITY AND CULTURE QUIZ.



Please note that this quiz is not a "test!" Your answers will not be shared with anyone. It is also important to note that cultural competence is a process and not an endpoint. A high score on this quiz does not "certify" or qualify you as a culturally competent provider! **Rather, the purpose of this quiz is to stimulate your thinking about cultural competence and help you to reflect on your experience, knowledge, and attitudes regarding culturally diverse populations.** This may be a good staff meeting exercise.

The quiz takes about ten minutes - there are 23 multiple choice and true/false questions. Once you complete the quiz, you can choose to learn more about any of the topics by exploring in-depth readings and following suggested activities. The topics covered in the quiz are:

- clinical outcomes
- medical history & diagnosis
- working with an interpreter
- common health problems
- body language
- culturally competent organizations



- prior assumptions and prejudices
- patient compliance
- backgrounds of cultural groups
- common beliefs and cultural practices
- relating to patients' families

Take the Quiz. — <http://erc.msh.org/quiz.cfm?action=question&qt=all&module=provider&language=english>

INTRODUCING THE NLM NATIVE VOICES IPAD APP



The App presents video interviews with tribal elders, healers, and other prominent people who practice traditional medicine, Western medicine, or a combination of both. From their unique experiences and perspectives, they weave a tapestry of stories of the vibrant and diverse cultures and medicine ways of Alaskan Natives, Native Americans, and Native Hawaiians. Other video clips provide an exhibition overview and highlights of the 4,400 mile journey of the totem pole specially created for the exhibition. The Native Voice App works on all iPads with iOS 4.2 and higher. To **download** the free App, go to the Apple iTunes store and type in "NLM Native Voices."



Curricula Enhancement Module Series

A project of the National Center for
Cultural Competence
Georgetown University
Center for Child and Human Development

The curricula enhancement series centers on four key content areas:

- Cultural awareness
- Cultural self-assessment
- Process of inquiry -- communicating in a multicultural environment
- Public health in a multicultural environment

The curricula enhancement module series is designed to:

- Assist faculty in incorporating four key content areas into existing curricula that are important to cultural and linguistic competence in public health
- Provide a set of defined areas of knowledge, skills, and awareness related to each core content area
- Offer relevant materials, articles, publications, and other multimedia resources for each core content area
- Provide faculty with instructional and self-discovery strategies



TRIVIA CONTEST:



First 3 to answer the questions wins a free PEDIATRIC Crash Card Reference (\$25 value) or Pedi-pad backboard pad- Email rsuzor@mt.gov

1. What are the symptoms of hyperthermia?
2. Recent exposure to meth likely causes what?
3. What is Montana's rate of methamphetamine consumption?

TRAINING RESOURCES: from CDC and IHS

[Safe Native American Passengers - Training for Transporting Children](#)

[The Sleep Safe Fire Safety Program - Mobilizing Communities in Fire Safety](#)

[Healthy Native Babies Project Workbook Packet \(PDF, 3.6 MB\)](#)

(National Institute of Child Health and Human Development, NIH)

This packet, which includes the Healthy Native Babies Project Workbook, Healthy Actions for Native Babies Handout, Toolkit disk, and Toolkit User Guide, describes ways to reduce the risk for SIDS among American Indian/Alaska Native (AI/AN) babies.

[Honor the Past, Learn for the Future: Reduce the Risk for Sudden Infant Death Syndrome \(SIDS\) \(PDF, 1.8 MB\)](#)

(National Institute of Child Health and Human Development, NIH)

This single sheet lists ways to reduce the risk for SIDS among American Indian/Alaska Native babies.

[Safe Sleep for Your Baby \(PDF, 925 KB\)](#)

(National Institute of Child Health and Human Development, NIH)

This brochure focuses on risk factors common among American Indian/Alaska Native communities and explains ways parents and caregivers can reduce the risks of SIDS and other sleep-related causes of infant death and provide a safe sleep environment for infants.

[How Mother Bear Taught the Children About Lead \(PDF, 3.877 KB\)](#)

(Healthy Environments for Children Initiative for the Penobscot Indian Nation)

[Knees Lifted High](#)

Rain That Dances introduces Thunder Cloud, his best friend, to Mr. Eagle who encourages the boys to be physically active every day. Eagle Book Series animated feature [7:36 minutes]

[A Plate Full of Color](#)

Introduces Miss Rabbit and the boys' friends, Little Hummingbird and Simon. Miss Rabbit teaches the value of eating a variety of colorful and healthy foods. Eagle Book Series animated feature [8:10 minutes]

[Through the Eyes of the Eagle](#)

Introduces the characters of Mr. Eagle and Rain That Dances, the American Indian boy he befriends. Mr. Eagle reminds the young boy of the healthy ways and wisdom of his elders. Eagle Book Series animated feature [6:36 minutes]

[Tricky Treats](#)

Introduces the character of Coyote, a trickster, and shows children the difference between healthy snacks and sweet treats. Eagle Book Series animated feature [10:50 minutes]

Infants

[Eliminate Disparities in Infant Mortality](#)

